CHANGE OF STATUS IN and/or DISCONTINUANCE OF A.I.T. PROGRAM

Health Professions Bureau
Indiana State Board of Health Facility Administrators
402 West Washington Street, Room W066
Indianapolis, Indiana 46204
317-234-2051
http://www.in.gov/hpb/boards/isbhfa

Name of Administrator-in-Training: _____

Name of Preceptor: _____

Facility Name and Address: _____
_____
_____

Facility Telephone Number: _____

I do hereby notify the Board of the following change(s):

_____**Change of Preceptor requested** _____Effective Date
New preceptor MUST complete a Preceptor Application form; you must receive notification of approval/denial of new preceptor prior to beginning program with another preceptor

_____**Discontinuance of AIT program** _____Effective Date

Other, please specify:_____

Identify which areas of training (i.e. orientation, nursing), if any, were completed by the AIT from the inception of the training to the date of discontinuance or change of status:

_____
_____
_____

Reasons and/or Comments:_____
_____

I hereby swear or affirm under the penalties of perjury that the above statements are true, complete and correct.

Signature_____ License No._____ Date_____
(Preceptor)

Signature_____ Date_____
(AIT)